

Foucault, Michel. "Message ou bruit?" In *Concours médical*, 88<sup>e</sup> année (22 octobre 1966): 6285f (colloque sur la nature de la pensée médicale); reprinted in M.F., *Dits et Écrits I* (Paris: Gallimard, 1994): 557-560.

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## Message or noise

In order to "situate" medicine amidst the other forms of knowledge, we have been, until now, using linear representations. Above the body, the soul; below the level of the organism, tissues. Therefore, medicine was grappling with psychology, psychopathology on one hand, and with physiology on the other hand. But the discussions I've just read offer us new kinships, either diagonal or lateral. The problems medicine deals with seem isomorphic to those found in other fields, in particular with disciplines interested in language or which might work like language. These fields are certainly not related through "their object" to medicine; however the latter, understood as theory-and-practice, may be structurally analogous to them.

We repeatedly say, since Balint, that the patient sends one or several "messages" which the doctor listens to and interprets. This paves the way for many kinds of naïve humanisms on the dubious theme of the "patient-doctor relationship".

In fact for a "message" to exist, several conditions must be met:

- first, there must be a noise (in the case of medicine, this primordial noise is the "non-silence of organs")
- second, this noise must be "constituted by" or be the "bearer of" various discontinuous elements; that is elements which can be isolated from one another using specific criteria.
- then These elements must be associated, in a constant way, to other elements that provide meaning (for medicine, it can be the "disease", or the "prognosis", or therapeutic indications).
- finally these elements must be linked to one another following some kind of regularities.

But the disease does not send any “message”, since the message relies on a “code” based on the preceding rules. There is no code in nature, as unnatural as nature can be. The disease only “makes noise”, and it is already good enough. All the rest, it is the doing of medicine, and medicine does even more than it would be ready to accept. We could certainly proceed to a three-level analysis of these operations.

## The making of a code

For a century and a half (and certainly not since Hippocrates, the poor fellow), clinical experience has isolated, in the noise made by the disease, a certain number of traits, which enable the definition of the elements that are part of a “pathological message”.

Thus, medicine has:

- brushed aside a certain number of noises deemed as being not relevant
- defined the criteria that allow for the recognition of the elements in the message and their individualization;
- set the rules of substitution enabling the translation of the message.

Of course, this code is constantly changing:

- When it is the rules of substitution that change, we then claim that “medical knowledge” is progressing.
- When it is the individualization principles of the elements that change, we then claim that “methods of observation” have been perfected.
- When one starts to define the elements of the message, where one was only hearing noise before, it is because medicine has integrated new domains.

The first changes are frequent, the second rare, and the third, exceptional. Freud transformed the patients’ utterances – which were considered as noise before him – into something that could be understood as a message. From then on (and of course, using different codes), the various forms of medicine have heard the patients’ utterances as messages to be deciphered.

One must not say that there are two messages but:

- now, there is a noise in which we hear more elements of the message than we could hear before (a whole part of the noise, that was muffled before, starts to speak);
- but this victory won over noise has not been secured by means of a single code and, maybe, will never be. It is probable we will win new victories, but only thanks to a new code, etc. Since the disease has nothing to say, there is no reason for a single code to succeed in “informing” all this noise. This first theoretical operation has been carried out – and that since the beginning of the 19<sup>th</sup> century – by the whole field of medicine, understood both as a body of knowledge and an institution. These are the rules taught to students in medical schools and in hospitals.

## Listening to the message

In his practice, the doctor does not deal with a patient, it goes without saying, but not with a suffering person either, and above all, thank God, not a “human being”. He neither deals with a body, nor a soul, nor both at the same time, nor their mixture. He deals with noise. Through this noise, he has to hear the elements of the message. To hear it, the doctor needs:

- to cancel out the noise, to close his ears to everything that is not an element of the message;
- to recognize (the two operations are obviously correlated) the distinctive traits of each element;
- and to record them progressively as they are emerging.

But, here is the catch.

The difference between a doctor and a vice consul is that the latter waits for the end of the message which is encoded, whereas the former cannot, and must not wait for the noise made by the disease to reach its end, that is to say either “recovery” or “death”. Hence the obligation, after a certain listening time, to start translating (once more, this translation can be a simple prescription). The difficulty with the diagnosis lies here, even if one has to understand by diagnosis the doctor’s most elementary answer to the message of the disease.

## Models and their use

In order to translate the message as soon as possible, it is necessary to use models, i.e. forms (configurations or sequences of signals already heard). These models can and must be of two kinds:

- those that allow to select among the elements, those that pertain to different functional levels (psychological, organic injury, or physiological adaptation). One then invokes a “grammatical” model, allowing to distinguish the great categories to which signals can belong;
- Those which allow one to risk a translation, i.e. to put the elements of the message in correlation with the elements of a previously defined disease.

These second types of models can in turn be used in two ways:

- either, one is certain that the message belongs to a very narrow set, and the number of models to which it corresponds is not really significant. Then, one can think that all the models that fall under this set are equipotential and consequently choose as an “interpretant” the model offering the best correlation with the recorded message. This is the diagnosis made by the “expert”;
- or (this is what happens for the general practitioner), the set to which the message belongs is not theoretically but practically infinite. Hence the choice of a preferred model, for the reason that it has a higher probability (due to internal or external factors), even if it means abandoning, modifying or specifying the model.

One wonders if the theory of medical practice could not be revised in terms that are no longer those of positivism, but in terms such as those developed today by practices such as language analysis, or information processing.

When will we be witnessing a “seminar” gathering medical doctors, language theoreticians and all the related sciences?